BIRTHS AND AVERAGE LENGTH OF STAY, NEWBORNS

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This table has been modified to facilitate adding newborn utilization rates to utilization rates reported in the Inpatient Utilization - General Hospital/Acute Care measure.*
- ➤ *Stratification of utilization data for newborns by maternal age has been deleted.*

Description

This table summarizes utilization information on newborns during the reporting year. This information is reported on total newborns, well newborns and complex newborns.

Specifications

Calculation:

Medicaid: Tables 5I-1a, 5I-1b, 5I-1c and 5I-1d are constructed using Table 5I-1 as a template. Report Total Number of Newborns, Newborns/1,000 Female Member Months, Newborns/1,000 Member Months, Days, Days per 1,000 Member Months, and Average Length of Stay for the newborns in the Medicaid eligibility category that each table addresses.

Commercial: Tables 5I-2a and 5I-2b are constructed using Table 5I-2 as a template. Report Total Number of Newborns, Newborns/1,000 Female Members per Year, Newborns/1,000 Members per Year, Days, Days per 1,000 Members per Year, and Average Length of Stay for newborns in the payer group that each table addresses.

Definition of Newborn Care

Newborns are identified and reported separately from maternity members. Newborn care is defined as care provided from birth to discharge to home. If a newborn is transferred from one hospital to another and has never gone home, the care is still newborn care.

Newborns born in an inpatient setting and at birthing centers should be included in this measure. For newborns delivered in birthing centers, count one day of stay.

Some health plans do not keep separate records on well newborns. An approximation that counts the number of newborns and days associated with their stays should be developed by plans that do not have separate discharge abstracts for newborns who leave the hospital at the same time as their mother. For example, use the mother's length of stay as a proxy for the well newborn's length of stay. To allow for instances in which the mother is not a member of the plan but the newborn is a member, plans may also need to develop a method that links the newborn to the mother. Provide documentation for the approach used.

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Total Newborns

Plans that complete discharge abstracts for newborns should use:

DRG codes: 385 - 391.

OR

ICD-9-CM codes: Any inpatient discharge with a principal or other ICD-9-CM diagnosis code of V30.x-V39.x (this excludes stillborns).

Newborns are further separated into complex and well newborns.

Complex Newborns

Newborns are identified as complex if: 1) their LOS is greater than or equal to five days or 2) their LOS is less than five days and the newborn expired. Expired newborns are those with a patient status code (Form Locator 22) equal to 20-29.

Well Newborns

Well newborns are newborns who are not defined as complex and have LOS of less than five days.

Notes

- The specifications do not address newborns transferred to another facility. If a health plan has the capability to link discharges for transferred newborns, the LOS calculations should reflect both discharges combined. If a health plan does not have this capability, the transferred newborns should be classified as complex. Under no circumstances should a newborn be counted more than once. Refer to Table 1F to identify and count multiple births.
- Newborns who are not members of the health plan at the time of birth should not be counted in Table 5I.
- The CPM recognizes that the definition of well and complex newborns on the basis of the length of stay has problems. A methodology to identify well and complex newborns based on clinical coding is being developed and evaluated.
- Health plans should document the percentage of their newborn population that was hospitalized in jurisdictions that have mandated a minimum covered LOS for newborns and specify the minimum length(s) of stay.

Template Table 5I-1: Births and Average Length of Stay, Newborns: Medicaid

Total Member Months (All Ages) _____

Total Female Member Months (10-49) _____

	Number of Newborns	Newborns/1,000 Female Member Months (10-49)	Newborns, Discharges/ 1,000 Member Months	Days	Days/1,000 Member Months	Average Length of Stay
All Newborns						
Mother is Plan Member						
Mother not Plan Member*						
Well Newborns						
Mother is Plan Member						
Mother not Plan Member*						
Complex Newborns						
Mother is Plan Member						
Mother not Plan Member*						

* Include all covered babies born to mothers who are not members of the health plan.

Template Table 5I-2: Births and Average Length of Stay, Newborns: Commercial

Total Member Months (All Ages) _____

Total Female Member Months (10-49) _____

	Number of Newborns	Newborns/1,000 Female Members per Year (10-49)	Newborns, Discharges/1,000 Members per Year	Days	Days/1,000 Members per Year	Average Length of Stay
All Newborns						
Mother is Plan Member						
Mother not Plan Member*						
Well Newborns						
Mother is Plan Member						
Mother not Plan Member*						
Complex Newborns						
Mother is Plan Member						
Mother not Plan Member*						

* Include all covered babies born to mothers who are not members of the health plan.

MENTAL HEALTH UTILIZATION — INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- ➤ *The age stratification was changed to correspond to age categories used in other tools measuring performance in behavioral health.*
- ➤ *A subtotal, summarizing data on male and female members in each age group, is provided.*

Description

This table summarizes utilization of inpatient mental health services, stratified by age and sex.

Specifications

Calculation:

Medicaid: Tables 5J-1a, 5J-1b, 5J-1c and 5J-1d are constructed using Table 5J-1 as a template. Report Discharges, Discharges/1,000 Member Months, Days of Inpatient Care and Average Length of Stay for members in the Medicaid eligibility category that each table addresses.

Commercial and Medicare risk: Tables 5J-2a, 5J-2b and 5J-3 are constructed using Table 5J-2/3 as a template. Report Discharges, Discharges/1,000 Members per Year, Days and Average Length of Stay for members in the payer group that the table addresses.

Refer to the algorithm provided on the following pages to identify inpatient care.

Note: *Table 5J should reflect inpatient days only. Days associated with day/night or partial hospitalization should be excluded.*

Template Table 5J: Mental Health Utilization — Inpatient Discharges and Average Length of Stay, by Age and Sex: Medicaid

	Member Months		
Age	**Male**	**Female**	**Total**
0-12			
13-17			
18-64			
65+			
Unknown			
Total			

Age	Sex	Discharges	Discharges/1,000 Member Months	Days*	Average Length of Stay
0-12	Male				
	Female				
	Total				
13-17	Male				
	Female				
	Total				
18-64	Male				
	Female				
	Total				
65+	Male				
	Female				
	Total				
Unknown	Male				
	Female				
	Total				
Total	Male				
	Female				
	Total				

* This table should reflect inpatient days only. Days associated with day/night or partial hospitalization should not be included in this table.

Template Table 5J-2/3: Mental Health Utilization — Inpatient Discharges and Average Length of Stay, by Age and Sex: Commercial and Medicare Risk (reported separately)

	Member Months		
Age	**Male**	**Female**	**Total**
0-12			
13-17			
18-64			
65+			
Unknown			
Total			

Age	Sex	Discharges	Discharges/1,000 Members	Days*	Average Length of Stay
0-12	Male				
	Female				
	Total				
13-17	Male				
	Female				
	Total				
18-64	Male				
	Female				
	Total				
65+	Male				
	Female				
	Total				
Unknown	Male				
	Female				
	Total				
Total	Male				
	Female				
	Total				

* This table should reflect inpatient days only. Days associated with day/night or partial hospitalization should not be included in this table.

MENTAL HEALTH UTILIZATION — PERCENTAGE OF MEMBERS RECEIVING INPATIENT, DAY/NIGHT CARE AND AMBULATORY SERVICES

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- ➤ *The age stratification was changed to correspond to age categories used in other tools measuring performance in behavioral health.*
- ➤ *A subtotal, summarizing data on male and female members in each age group, is provided.*
- ➤ *Codes have been modified.*

Description

This measure reports the number and percentage of members receiving mental health services during the reporting year in the following categories: Any Mental Health Services (inpatient, day/night, ambulatory), Inpatient Mental Health Services, Day/Night Mental Health Services and Ambulatory Mental Health Services. Report in each category the number of members who received the respective service and, of all enrollees with a mental health benefit, the percentage who received the respective service. This information is reported by age and sex.

This table is intended to give an overview of the extent to which the plan uses the different levels of mental health care.

Specifications

Calculation:

Medicaid, Commercial and Medicare Risk: Tables 5K-1a, 5K-1b, 5K-1c, 5K-1d, 5K-2a, 5K-2b and 5K-3 are constructed using Table 5K as a template. Report the number and percentage of health plan members in the payer/eligibility group that each table addresses who receive Any Mental Health Services, Inpatient, Day/Night or Ambulatory Mental Health Services.

Refer to the algorithm provided on the following pages to identify inpatient, day/night and ambulatory care. A member could be counted in all four columns if he/she has received inpatient, day/night and ambulatory mental health services. A member should be counted in each column only once, regardless of his/her number of visits.

In each column, for members who have had more than one encounter, count the first visit in the reporting year and report the member in the respective age category as of the date of discharge.

Notes

- Because some health plans may offer different benefits for inpatient and outpatient mental health services, denominators in the columns of this table may vary. The denominator in the column "any mental health services" should reflect all enrollees who have any mental health benefit.
- Member months of enrollment of members with the respective benefit are used as the denominator for calculating the percentage of members receiving any mental health services, inpatient, day/night or ambulatory mental health services. Other methods of defining the denominators are being considered for future versions of HEDIS.

Template Table 5K: Mental Health Utilization — Percent of Members Receiving Inpatient, Day/Night Care, and Ambulatory Services: Medicaid, Commercial and Medicare Risk (reported separately)

	Member Months		
Age	**Male**	**Female**	**Total**
0-12			
13-17			
18-64			
65+			
Unknown			
Total			

		Any Mental Health Services		Inpatient Mental Health Services		Day/Night Mental Health Services		Ambulatory Mental Health Services	
Age	**Sex**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
0-12	Male								
	Female								
	Total								
13-17	Male								
	Female								
	Total								
18-64	Male								
	Female								
	Total								
65+	Male								
	Female								
	Total								
Unknown	Male								
	Female								
	Total								
Total	Male								
	Female								
	Total								

Algorithm for identifying inpatient, day/night and ambulatory services, to be used as appropriate to complete Tables 5J and 5K:

Three levels of mental health utilization are assessed: inpatient, day/night and ambulatory. The day/night category captures the growing segment of partial hospitalizations.

Inpatient: Inpatient care for mental health diagnoses, at either a hospital or a treatment facility:

DRG codes: 424-432

OR

ICD-9-CM codes: Principal diagnosis codes in the range of 290.xx, 293.xx-302.xx and 306.xx-316.xx. Note that diagnosis codes 317-319 should be reported as medicine or surgery (Tables 5F-1).

Note: DSM-IV codes mirror ICD-9-CM codes. A health plan that has access only to DSM-IV codes should use and document them. Follow the specifications outlined above for ICD-9-CM codes.

Day/Night Care: Mental health and chemical dependency services are difficult to count as separate reporting entities because unique CPT-4 codes do not currently exist for chemical dependency services. However, mental health can be separated from chemical dependency, because it is common practice to use identical psychiatry CPT-4 codes accompanied by specific ICD-9-CM codes to separate the type of services rendered. Although this approach is less than perfect, it will help gain a better understanding of resource use in this area of great public concern.

Instructions:

- Use CPT-4 code ranges accompanied by ICD-9-CM codes to separate mental health and chemical dependency. ICD-9-CM codes should be consistent with those used to capture inpatient discharges. The principal diagnosis code reported on the claim should be used regardless of overlapping MH/CD problems in an individual case. Services provided by nonphysician practitioners should be counted the same as those provided by physicians.

  Include all other ambulatory care MH/CD service day treatment and partial hospitalization programs, because these programs represent a significant amount of services rendered. These services could be represented by Level III HCPCS codes. They are reported under day/night care, separate from ambulatory services.

  Exclude any utilization the plan knows is designated as "inpatient" by the part of the type of bill code that refers to location of service.

- Count the following CPT-4 procedure codes only if they appear in conjunction with the ICD-9-CM diagnosis codes for mental health (290.xx, 293.xx-302.xx, 306.xx-316.xx):

90801	Diagnostic Assessment
90820	Interactive Interview Examination
90841	MD Psychotherapy
90842	MD Psychotherapy
90843	MD Psychotherapy

90844	MD Psychotherapy
90845	MD Psychoanalysis
90846	Family Psychotherapy without Patient
90847	Family Psychotherapy
90849	Multifamily Group Therapy
90853	Group Psychotherapy
90855	Interactive Individual Medical Psychotherapy
90857	Interactive Group Medical Psychotherapy
90862	Pharmacology Management
90870-90871	Electroconvulsive Therapy

Exclude the following CPT-4 codes from this category:

90880	Medical Hypnotherapy
90882	Environmental Intervention
90887	Interpretation of Tests
90889	Preparation of Reports
90900-90915	Biofeedback

Note: *Because more than 90% of mental health services can be captured with a minimal number of codes, collection of these additional and extraneous codes above is too costly for a relatively small gain in data. In addition, codes used for hypnotherapy and biofeedback can be applied to non-mental health services, which makes their reporting problematic for this category.*

Separate the CPT-4 codes identified in Step 2, in conjunction with the ICD-9-CM codes, into day/night care as follows:

Revenue code (Form Locator 42): 912 (Psychiatric/psychological services-partial hospitalization)

AND

Type of Bill code (Form Locator 4): 13X (hospital outpatient) or 43X (Christian Science hospital outpatient), where "X" refers to any third digit.

Ambulatory: To identify ambulatory services, repeat Steps 1 and 2 above under day/night care, and separate ambulatory as follows:

Revenue code (Form Locator 42):

900 (Psychiatric/Psychological Treatments, General Classification), or

901 (Psychiatric/Psychological Treatments, Electroshock Treatment), or

902 (Psychiatric/Psychological Treatments, Milieu Therapy), or

903 (Psychiatric/Psychological Treatments, Play Therapy), or

909 (Psychiatric/Psychological Treatments, Other), or

910 (Psychiatric/Psychological Services, General Classification), or

911 (Psychiatric/Psychological Services, Rehabilitation), or

914 (Psychiatric/Psychological Services, Individual Therapy), or

915 (Psychiatric/Psychological Services, Group Therapy), or

916 (Psychiatric/Psychological Services, Family Therapy), or

918 (Psychiatric/Psychological Services, Testing), or

919 (Psychiatric/Psychological Services, Other).

AND

Type of Bill code (Form Locator 4): 13X (Hospital Outpatient) or 43X (Christian Science hospital outpatient), where "X" refers to any third digit.

Note: *Ambulatory services delivered in any setting (hospital outpatient clinic, physician's office, etc.) should be counted as ambulatory services in Tables 5K-1. Plans will only need to use the revenue code and type of bill code to separate ambulatory from inpatient services if data from the UB-92 are used.*

READMISSION FOR SELECTED MENTAL HEALTH DISORDERS

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- ➤ *This measure was broadened to include the mental health diagnoses specified in Medicaid HEDIS, in order to be consistent with the Follow-Up After Hospitalization for Mental Illness measure in the Effectiveness of Care domain.*
- ➤ *The age stratification was changed to correspond to age categories used in other tools measuring performance in behavioral health.*
- ➤ *A subtotal, summarizing data on male and female members in each age group, is provided.*

Description

The number of members readmitted within 90 and 365 days of hospitalization for selected mental health disorders and the percentages of those rehospitalized versus the number of all members hospitalized for these mental health disorders in the year before the reporting year. This information is reported by age and sex.

This measure is intended to help assess the extent of rehospitalization required after inpatient mental health treatment.

Specifications

Calculation:

Medicaid, Commercial and Medicare risk: Tables 5L-1a, 5L-1b, 5L-1c, 5L-1d, 5L-2a, 5L-2b and 5L-3 are constructed using Table 5L as a template. Report the number of members, by age and sex, hospitalized for any selected mental health disorder in the year prior to the reporting year, and the number and percentage of these members who were readmitted for any selected mental health disorder within 90 days and within 365 days after discharge.

Note: *This measure applies to inpatient admissions and readmissions only; day/night care should not be included.*

The Selected Mental Health Disorders are defined by a principal diagnosis of:

ICD-9-CM 295.xx	Schizophrenic disorders
ICD-9-CM 296.0x	Manic disorder, single episode
ICD-9-CM 296.1x	Manic disorder, recurrent episode
ICD-9-CM 296.2x	Major depressive disorder, single episode
ICD-9-CM 296.3x	Major depressive disorder, recurrent episode
ICD-9-CM 296.4x	Bipolar affective disorder, manic
ICD-9-CM 296.5x	Bipolar affective disorder, depressed
ICD-9-CM 296.6x	Bipolar affective disorder, mixed

ICD-9-CM	296.7x	Bipolar affective disorder, unspecified
ICD-9-CM	296.8x	Manic-depressive psychosis, other and unspecified
ICD-9-CM	296.9x	Other and unspecified affective psychoses
ICD-9-CM	297.x	Paranoid states
ICD-9-CM	298.x	Other nonorganic psychoses
ICD-9-CM	299.xx	Psychoses with origin specific to childhood
ICD-9-CM	301.x	Personality disorders
ICD-9-CM	308.x	Acute reaction to stress
ICD-9-CM	309.xx	Adjustment reaction
ICD-9-CM	311	Depressive disorder, not otherwise classified
ICD-9-CM	312.xx	Disturbance of conduct, not elsewhere classified
ICD-9-CM	313.xx	Disturbance of emotions specific to childhood and adolescence
ICD-9-CM	314.xx	Hyperkinetic syndrome of childhood

Instructions:

- Identify all potential discharges during the year prior to the reporting year (calendar year 199x-1) for each member with a principal diagnosis listed above. If a member had more than one discharge, use the latest discharge, which becomes the "index episode." Exclude index episodes for those members not continuously enrolled for 365 days (allowing no more than one break in service not to exceed 45 days) after the discharge date of the index episode.
- For all remaining index episodes, indicate whether the member was readmitted to an inpatient hospital within 365 days of the latest discharge for related care of one of the selected mental health disorders. Count only readmissions that occur during the reporting year. To determine if an episode is related care, search the diagnosis codes (up to the first five ICD-9-CM codes) associated with the episode for one or more of the mental health diagnosis codes identified above. If at least one of the first five ICD-9-CM codes relates to one of the selected mental health disorders, the episode is considered a related readmission. Count one readmission per member.
- To obtain the 90-day readmission rate, identify those members who were readmitted within 365 days for related care of one of the selected mental health disorders and identify the subset that represents readmissions within 90 days.

Notes

- There are a number of ways to calculate readmission rates. While the method used here misses readmissions that occur during the same calendar year, it does detect readmissions within a specific time window, thus allowing comparison among health plans. A method allowing more complete capturing of readmissions is being developed and evaluated.
- Classify members according to their age as of the discharge date from the index episode.

Template Table 5L: Readmission for Selected Mental Health Disorders: Medicaid, Commercial and Medicare Risk (reported separately)

Age	Sex	Hospitalized in Year Prior to Reporting Year	Readmitted within 90 Days of Prior Year's Index Discharge		Readmitted with 365 Days of Prior Year's Index Discharge	
			Number	Percent	Number	Percent
0-12	Male					
	Female					
	Total					
13-17	Male					
	Female					
	Total					
18-64	Male					
	Female					
	Total					
65+	Male					
	Female					
	Total					
Unknown	Male					
	Female					
	Total					
Total	Male					
	Female					
	Total					

Chemical Dependency Utilization — Inpatient Discharges and Average Length of Stay

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- *The age stratification was changed to correspond to age categories used in other tools measuring performance in behavioral health.*
- *A subtotal, summarizing data on male and female members in each age group, is provided.*

Description

This table summarizes utilization of inpatient chemical dependency services, stratified by age and sex.

Specifications

Calculation:

Medicaid: Tables 5M-1a, 5M-1b, 5M-1c and 5M-1d, are constructed using Table 5M-1 as a template. Report Discharges, Discharges/1,000 Member Months, Days and Average Length of Stay for members in the Medicaid eligibility category that each table addresses.

Commercial and Medicare risk: Tables 5M-2a, 5M-2b and 5M-3 are constructed using Table 5M-2/3 as a template. Report Discharges, Discharges/1,000 Members per Year, Days and Average Length of Stay for members in the payer group that each table addresses.

Refer to the algorithm provided on the following pages to identify inpatient care.

Note: Tables 5M should reflect inpatient days only. Exclude days associated with day/night or partial hospitalization.

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Template Table 5M-1: Chemical Dependency Utilization — Inpatient Discharges and Average Length of Stay, by Age and Sex: Medicaid

	Member Months		
Age	**Male**	**Female**	**Total**
0-12			
13-17			
18-64			
65+			
Unknown			
Total			

Age	Sex	Discharges	Discharges/1,000 Member Months	Days*	Average Length of Stay
0-12	Male				
	Female				
	Total				
13-17	Male				
	Female				
	Total				
18-64	Male				
	Female				
	Total				
65+	Male				
	Female				
	Total				
Unknown	Male				
	Female				
	Total				
Total	Male				
	Female				
	Total				

*This table should reflect inpatient days only. Days associated with day/night or partial hospitalization should not be included in this table.

Template Table 5M-2/3: Chemical Dependency Utilization — Inpatient Discharges and Average Length of Stay, by Age and Sex: Commercial and Medicare Risk (reported Separately)

	Member Months		
Age	**Male**	**Female**	**Total**
0-12			
13-17			
18-64			
65+			
Unknown			
Total			

Age	Sex	Discharges	Discharges/1,000 Members	Days*	Average Length of Stay
0-12	Male				
	Female				
	Total				
13-17	Male				
	Female				
	Total				
18-64	Male				
	Female				
	Total				
65+	Male				
	Female				
	Total				
Unknown	Male				
	Female				
	Total				
Total	Male				
	Female				
	Total				

*This table should reflect inpatient days only. Days associated with day/night or partial hospitalization should not be included in this table.

CHEMICAL DEPENDENCY UTILIZATION — PERCENTAGE OF MEMBERS RECEIVING INPATIENT, DAY/NIGHT CARE AND AMBULATORY SERVICES

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- *The age stratification was changed to correspond to age categories used in other tools measuring performance in behavioral health.*
- *A subtotal, summarizing data on male and female members in each age group, is provided.*
- *Codes have been modified.*

Description

This measure reports the number and percentage of members receiving chemical dependency services during the reporting year in the following categories: Any Chemical Dependency Services (inpatient, day/night, ambulatory), Inpatient Chemical Dependency Services, Day/Night Chemical Dependency Services and Ambulatory Chemical Dependency Services. Report in each category the number of members who received the respective service and, of all enrollees with a chemical dependency benefit, the percentage that received the respective service. This information is reported by age and sex.

This table is intended to give an overview of the extent to which the plan uses the different levels of chemical dependency care.

Specifications

Calculation:

Medicaid, Commercial and Medicare risk: Tables 5N-1a, 5N-1b, 5N-1c, 5N-1d, 5N-2a, 5N-2b and 5N3 are constructed using Table 5N as a template. Report the number and percent of health plan members in the respective age and sex group who receive any chemical dependency services, inpatient, day/night or ambulatory chemical dependency services.

Refer to the algorithm provided on the following pages to identify inpatient, day/night and ambulatory care. A member could be counted in all four columns if he/she has received inpatient, day/night and ambulatory chemical dependency services. A member should be counted in each column only once, regardless of his/her number of visits.

In each column, for members who have had more than one encounter, count the first visit in the reporting year and report the member in the respective age category as of the date of discharge.

Note

- Member months of enrollment of members with the respective benefit are used as the denominator for calculating the percentage of members receiving any mental health services, inpatient, day/night or ambulatory mental health services. Other methods of defining the denominators are being considered for future versions of HEDIS.

Template Table 5N: Chemical Dependency Utilization — Percent of Members Receiving Inpatient, Day/Night Care, and Ambulatory Services: Medicaid, Commercial and Medicare Risk (reported separately)

	Member Months		
Age	**Male**	**Female**	**Total**
0-12			
13-17			
18-64			
65+			
Unknown			
Total			

		Any Chemical Dependency Services		Inpatient Chemical Dependency Services		Day/Night Chemical Dependency Servoces		Ambulatory Chemical Dependency Services	
Age	**Sex**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
0-12	Male								
	Female								
	Total								
13-17	Male								
	Female								
	Total								
18-64	Male								
	Female								
	Total								
65+	Male								
	Female								
	Total								
Unknown	Male								
	Female								
	Total								
Total	Male								
	Female								
	Total								

Algorithm for identifying inpatient, day/night and ambulatory services, to be used as appropriate to complete Tables 5M and 5N:

Three levels of chemical dependency treatment utilization are assessed: inpatient, day/night and ambulatory. The day/night category captures the growing segment of partial hospitalizations.

Inpatient: Inpatient care with chemical dependency as the principal diagnosis, including detoxification, at either a hospital or a treatment facility.

DRG codes: 433-437.

OR

ICD-9-CM codes: Principal diagnosis codes in the range of 291-292.9, 303.0-305.93, 965.0x, 965.8x, 967.xx, 968.5x or 969.xx.

Note: *ICD-9-CM code 967.xx may be used to identify chemical dependency in conjunction with a secondary diagnosis of dependency or other data source that substantiates chemical dependency.*

Note: *Diagnosis codes 980.0-980.9 should be reported as medicine or surgery (Tables 5F-1).*

Note: *DSM-IV codes mirror ICD-9-CM codes. A health plan that has access only to DSM-IV codes should use them and document it. Follow the specifications outlined above for ICD-9-CM codes.*

Day/Night Care: Mental health and chemical dependency services are difficult to count as separate reporting entities because unique CPT-4 codes do not currently exist for chemical dependency services. However, mental health can be separated from chemical dependency because it is common practice to use identical psychiatry CPT-4 codes accompanied by specific ICD-9-CM codes to separate the types of services provided. Although this approach is less than perfect, it will help gain a better understanding of resource use in this area of great public concern.

Instructions:

➤ Use CPT-4 code ranges accompanied by ICD-9-CM codes to separate mental health and chemical dependency. ICD-9-CM codes should be consistent with those used to capture inpatient discharges. The principal diagnosis code reported on the claim should be used regardless of overlapping MH/CD problems in an individual case. Services provided by nonphysician practitioners should be counted the same as those provided by physicians.

Include all other ambulatory care MH/CD service day treatment and partial hospitalization programs, because these programs represent significant services rendered. These services could be represented by Level III HCPCS codes. They are reported under day/night care, separate from ambulatory services. Exclude any utilization the plan knows is designated as "inpatient" by the part of the type of bill code that refers to location of service.

➤ Count the following CPT-4 procedure codes only if they appear in conjunction with the ICD-9-CM diagnoses codes for chemical dependency (291-292.9, 303.0-305.93, 965.0x, 965.8x, 967.xx, 968.5x or 969.xx):

90801	Diagnostic Assessment
90820	Interactive Interview Examination
90841	MD Psychotherapy
90842	MD Psychotherapy
90843	MD Psychotherapy
90844	MD Psychotherapy
90845	MD Psychoanalysis
90846	Family Psychotherapy without Patient
90847	Family Psychotherapy
90849	Multifamily Group Therapy
90853	Group Psychotherapy
90855	Interactive Individual Medical Psychotherapy
90857	Interactive Group Medical Psychotherapy
90862	Pharmacology Management
90870-90871	Electroconvulsive Therapy

Exclude the following CPT-4 codes from this category:

90880	Medical Hypnotherapy
90882	Environmental Intervention
90887	Interpretation of Tests
90889	Preparation of Reports
90900-90915	Biofeedback

Note: *Because more than 90% of mental health services can be captured with a minimal number of codes, collection of these additional and extraneous codes for this measure is too costly for a relatively small gain in data. In addition, codes used for hypnotherapy and biofeedback can be applied to non-mental health services, rendering their reporting problematic for this category.*

➤ Separate the CPT-4 codes identified in Step 2, in conjunction with the ICD-9-CM codes, into day/night care as follows:

Revenue code (Form Locator 42): 912 (Psychiatric/psychological services-partial hospitalization)

AND

Type of Bill code (Form Locator 4): 13X (Hospital outpatient) or 43X (Christian Science hospital outpatient), where "X" refers to any third digit.

Ambulatory: To identify ambulatory services, repeat Steps 1 and 2 above under day/night care and separate ambulatory as follows:

Revenue code (Form Locator 42): 944 (Drug rehabilitation) or 945 (Alcohol rehabilitation)

AND

Type of Bill code (Form Locator 4): 13X (Hospital outpatient) or 43X (Christian Science hospital outpatient), where "X" refers to any third digit.

Note: *Ambulatory services delivered in any setting (hospital outpatient clinic, physician's office, etc.) should be counted as ambulatory services in Tables 5N-1. Plans will only need to use the revenue code and type of bill code to separate ambulatory from inpatient services if data from the UB-92 are used.*

READMISSION FOR CHEMICAL DEPENDENCY

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ➤ *This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to the Medicare risk population as well.*
- ➤ *The age stratification was changed to correspond to age categories used in other tools measuring performance in behavioral health.*
- ➤ *A subtotal, summarizing data on male and female members in each age group, is provided.*

Description

This measure reports the number of members readmitted within 90 and 365 days of hospitalization for chemical dependency treatment and the percentages of those rehospitalized versus the number of all members hospitalized for chemical dependency treatment in the year before the reporting year. This information is reported by age and sex.

This table is intended to help assess the extent of rehospitalization required after inpatient chemical dependency treatment.

Specifications

Calculation:

Medicaid, Commercial and Medicare Risk: Tables 5O-1a, 5O-1b, 5O-1c, 5O-1d, 5O-2a, 5O-2b, 5O-3 are constructed using Table 5O as a template. Report the number of members hospitalized for chemical dependency in the year prior to the reporting year and the number and percentage of these members who were readmitted for chemical dependency treatment within 90 days and within 365 days after discharge.

Note: This measure applies to inpatient admissions and readmissions only; day/night care should not be included.

ICD-9-CM codes: Principal diagnosis codes in the range of 291-292.9, 303.0-305.93, 965.0x, 965.8x, 967.xx, 968.5x or 969.xx.

Diagnosis codes 980.0-980.9 should be reported as medicine or surgery (Table 5F-1).

Instructions:

- ➤ Identify all potential discharges during the year prior to the reporting year (calendar year 199x-1) for each member with a principal diagnosis listed above. If a member had more than one discharge, take the latest discharge, which becomes the "index episode." Exclude index episodes for those members not continuously enrolled for 365 days (allowing no more than one break in service, not to exceed 45 days) after the discharge date of the index episode.
- ➤ For all remaining index episodes, indicate whether the member was readmitted to an inpatient hospital within 365 days of the latest discharge for related care of chemical dependency. Only count readmissions that occur during the reporting year. To determine if an episode is related care, search the diagnosis codes (up to

the first five ICD-9-CM codes) associated with the episode for one or more of the chemical dependency codes identified above. If at least one of the first five ICD-9-CM codes relates to chemical dependency, consider the episode to be a related readmission. Count one readmission per member.

➤ To obtain the 90-day readmission rate, identify those members who were readmitted within 365 days for related care of chemical dependency and identify the subset that represents readmissions within 90 days.

Notes

➤ There are a number of ways to calculate readmission rates. While the method used here misses readmissions that occur during the same calendar year, it does detect readmissions within a specific time window, thus allowing comparisons among health plans. A methodology allowing more complete capturing of readmissions is being developed and evaluated.

➤ Classify members according to their age at the time of the discharge date of the index episode.

Template Table 50: Readmission for Chemical Dependency: Medicaid, Commercial and Medicare Risk (reported separately)

Age	Sex	Hospitalized in Year Prior to Reporting Year	Readmitted within 90 Days of Prior Year's Index Discharge		Readmitted with 365 Days of Prior Year's Index Discharge	
			Number	Percent	Number	Percent
0-12	Male					
	Female					
	Total					
13-17	Male					
	Female					
	Total					
18-64	Male					
	Female					
	Total					
65+	Male					
	Female					
	Total					
Unknown	Male					
	Female					
	Total					
Total	Male					
	Female					
	Total					

OUTPATIENT DRUG UTILIZATION

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ***This measure, from HEDIS 2.5 and Medicaid HEDIS, now applies to Medicare risk population as well.***
- ***Age stratification is more detailed for children and for members age 65 and older, to account for the demographic characteristics of the Medicaid and Medicare risk populations.***

Description

This measure summarizes data on outpatient utilization of drug prescriptions (Total Cost of Prescriptions, Average Cost of Prescriptions per Member per Month, Total Number of Prescriptions and Average Number of Prescriptions per Member per Year) during the reporting year, stratified by age.

Specifications

Calculation:

Medicaid, Commercial and Medicare Risk: 5P-1a, 5P-1b, 5P-1c, 5P-1d, 5P-2a, 5P-2b and 5P-3 are constructed using Table 5P as a template.

Plans may define "prescription" as either:

One 30-day (or less) supply of pharmaceuticals.

OR

One supply of pharmaceuticals for which the plan accepts a copayment.

Specify which method is used.

Total cost of prescriptions is defined as any copayments and/or deductibles made by a member, plus the total cost of ingredients and dispensing fee, where the total cost of ingredients excludes any discounts that the health plan negotiates.

Formulas:

- Average total cost of prescriptions per member per month = ([Total cost to health plan for drug ingredients – discounts] + dispensing fees + member copayments and deductibles)/member months for members with a drug benefit.
- Annual total number of prescriptions per member per year = (Total number of prescriptions/member months for members with a drug benefit) x 12 months.

Notes

- Member months in the accompanying table should include only those members with a pharmacy benefit.
- Copayment may equal zero.
- Count each refill as a separate prescription.
- Count rebates the pharmacy receives after sales as "discounts."
- Supplies (e.g., syringes) do not count towards this measure.
- Base the cost and number of prescriptions in the numerators only on prescriptions dispensed to members with a pharmacy benefit.
- Member copayments and deductibles are included in the cost calculation because employers and states are interested in knowing the total cost of prescriptions, not the cost to the health plan.
- We expect future versions of HEDIS to move toward the 30-day supply method. Plans that use mail-order pharmaceuticals will need to develop record-keeping systems consistent with this approach (i.e., the 30-day supply as the unit of analysis).

Template Table 5P: Outpatient Drug Utilization: Medicaid, Commercial and Medicare Risk (reported separately)

Age	Member Months
0-9	
10-19	
20-44	
45-64	
65-74	
75-84	
85+	

Specification Documentation: Prescription is defined as (check one)

One 30-day (or less) supply of pharmaceuticals

One supply of pharmaceuticals for which the health plan accepts a copayment

Age	Total Cost of Prescriptions	Average Cost of Prescriptions per Member per Month	Total Number of Prescriptions	Average Number of Prescriptions per Member per Year
0-9				
10-19				
20-44				
45-64				
65-74				
75-84				
85+				
Unknown				
Total				

NEW MEMBER ORIENTATION/EDUCATION

Summary of changes from HEDIS 2.5 and/or Medicaid HEDIS

- ***This measure, from Medicaid HEDIS, now applies to the commercial and Medicare populations as well.***
- ***A question on educational efforts targeted at particular populations has been added.***

Description

This measure solicits a narrative description of plan efforts to orient and educate new members (Medicaid, commercial and Medicare risk populations). It is reported separately for each population.

Specification

In 250 words or less (per population), describe:

- procedures used to educate and orient new members on methods for appropriately accessing and using plan services and
- any special targeted efforts to educate and orient particular populations (Medicaid, commercial and/or Medicare risk).